

BARIATRIC SURGERY REQUEST

PROVIDER NUMBER TELEPHONE NUMBER CLIENT INFORMATION CLIENT NAME SERVICE REQUEST INFORMATION SURGERY DESCRIPTION CLIENT MAME ICD-9 Dx CODES AND DESCRIPTION PERFORMING SURGEON CLIENT MEDICAL INFORMATION 1. Body Mass Index 2. Assessment of surgical risk: 3. Previous failure with weight loss programs: (List each program and approximate dates of participation) Weight Loss Program Approximate Dates a. Approximate Dates	PROVIDER INFORMATION										
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b. thru	-			thru	thr				b		
c. thru	-			thru	thr				C.		
d. thru	-			thru	thr				d.		
4. Is there co-morbidity related to: Yes No		No	es	Ye				morbidity related to:	4. Is there		
Obesity?				[•			
Diabetes?											
If yes, explain:								ain:	If yes, e		
Cardiac Disease?			٦	Г				ease?	Cardiac		
If yes, explain:			_	_							
Pulmonary Disease?		\neg	7	Г				Disease?	Pulmona		
If yes, explain:		_	_	_							
Joints/Back?				[
Other?				[

5.	Does the client have the ability to maintain the post-operative dietary changes required? Why or why not?	☐ Yes	☐ No
6.	 Please attach the following: Detailed history and physical exam Endocrine labs (thyroid and glucose tolerance or assessment of diabetes control/HbA1c) Renal and liver function tests 		

Fax: 360-586-1471 or mail to: Medical Request Coordinator HRSA

PO Box 45506

Olympia, WA 98504-5506